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# Southwestern MEDICINE

OFFICIAL JOURNAL OF THE SOUTHWESTERN MEDICAL ASSOCIATION AND EL PASO COUNTY MEDICAL SOCIETY

*February 1953*

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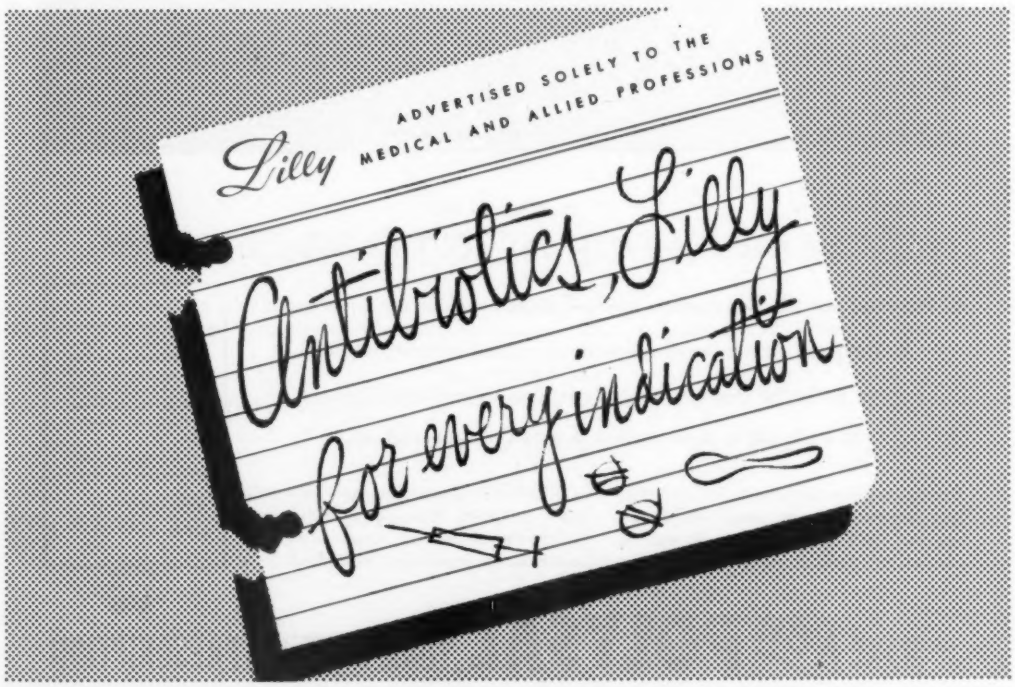


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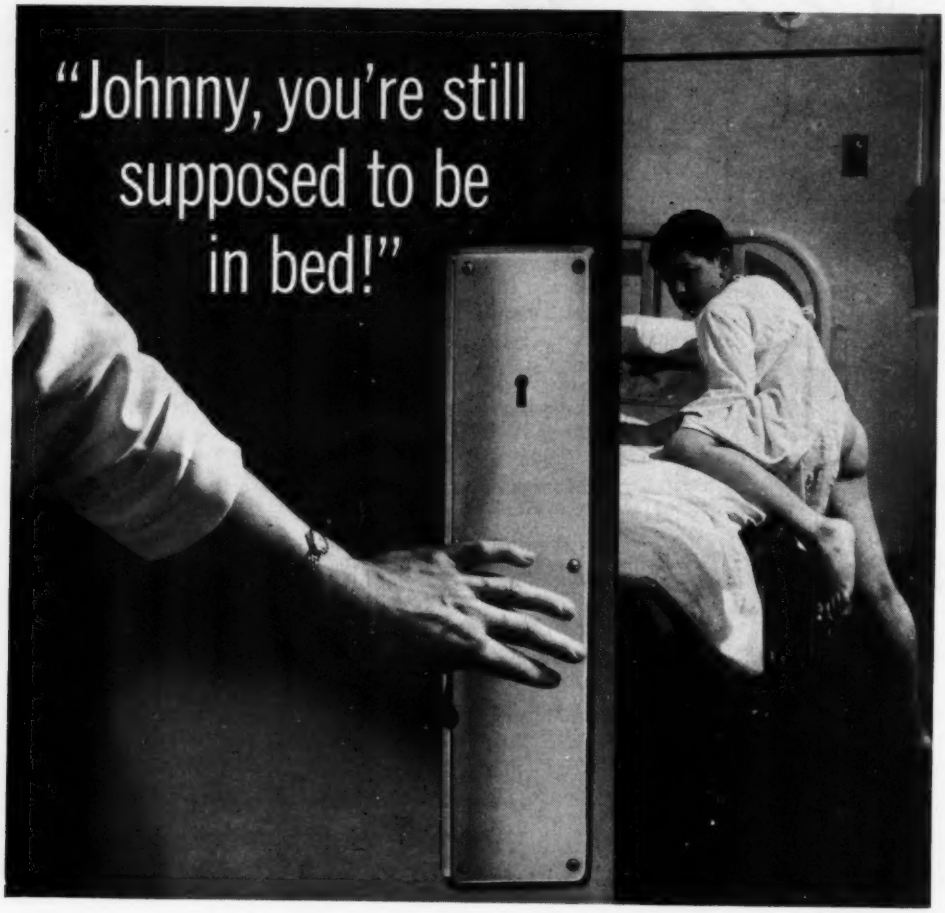


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1. Fox, C. L. Jr., et. al.: An Electrolyte Solution Approximating Plasma Concentrations with Increased Potassium for Routine Fluid and Electrolyte Replacement. J. A. M. A., March 8, 1952.

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# DISTRICT ONE MEDICAL ASSOCIATION TO MEET IN EL PASO FEBRUARY 13-14

The annual meeting of the District One Medical Association of Texas will be held Friday and Saturday, February 13 and 14, at the Turner Home of the El Paso County Medical Society, 1301 Montana St., El Paso.

A distinguished guest and speaker will be Dr. T. C. Terrell of Fort Worth, president of the Texas Medical Association, who will address the physicians and their wives on "The United Nations Educational, Scientific, and Cultural Organization (UNESCO)."

Another outstanding speaker will be Dr. Robert M. Moore, professor of surgery, medical branch, University of Texas, Galveston. He will talk on "Biliary Tract Surgery." Many physicians in District One are former students under Dr. Moore and will welcome the opportunity to renew acquaintance with their former mentor.

Dr. Moore will also speak on "Care of Malignant Lesions of the Colon and Rectum."

Eleven members of El Paso County Medical Society will deliver 20 minute talks on various scientific and medical subjects. Each talk will be followed by a five minute discussion period.

Registration fee of $2 will cover incidental expenses and cost of Friday's luncheon for the physicians. Ladies will be charged for their lunch at the time of their registration with the district auxiliary .

District One consists of eleven counties in extreme west Texas. They are: El Paso, Hudspeth, Culberson, Reeves, Loving, Ward, Winkler, Pecos, Jeff Davis, Presidio and Brewster.

Officers of the District One Medical Association are: J. Leighton Green, M. D., Councillor, El Paso; Charles Oswalt, M. D., Vice-Councillor, Fort Stockton; Jim Camp, M. D., President, Pecos; John W. O'Donnell, M. D., Vice-President, Alpine; and H. D. Garrett, M. D., Secretary-Treasurer, El Paso.

Physicians from New Mexico, Arizona and Northern Mexico are cordially invited to attend the District One sessions.

## THE PROGRAM

### FRIDAY, FEBRUARY 13

**8:30 — 9:00 A. M.**

REGISTRATION

**9:00 — 9:25 A. M.**

"Advantages and Disadvantages of Open and Closed Treatment of Burns"—*Dr. Willard Schuessler, El Paso*

**9:25 — 9:50 A. M.**

"Hypothyroidism — Often Forgotten"—*Dr. Jack A. Bernard, El Paso*

**9:50 — 10:15 A. M.**

"Interesting Cases of Foreign Bodies in Air and Food Passages"—*Dr. Haskell Hatfield, El Paso*

**10:15 — 10:30 A. M.**

— INTERMISSION —

**10:30 — 10:55 A. M.**

"Briefs on Gynecological Therapy"—*Dr. Clement C. Boehler, El Paso*

**10:55 — 11:20 A. M.**

"Cancer of the Prostate"—*Dr. James D. Bozzell, El Paso*

**11:20 — 11:45 A. M.**

"Treatment of Herpes Zoster Ophthalmicus with Protamide"—*Dr. W. G. Morrow, Jr., El Paso*

**12 — 1:30 P. M.**

Luncheon for members and their wives, to be served in the Turner Home
Immediately following lunch there will be a joint meeting upstairs of doctors and wives to hear an address by Dr. T. C. Terrell of Fort Worth, president of the Texas Medical Association. His topic will be the "United Nations Educational, Scientific and Cultural Organization" (U. N. E. S. C. O.).

**1:30 — 2:30 P. M.**

Address by DR. T. C. TERRELL, President of Texas Medical Association

**2:30 — 3:15 P. M.**

"Biliary Tract Surgery"----------*Dr. Robert M. Moore,*
Professor of Surgery, Medical Branch, University of Texas, Galveston

**3:15 — 3:40 P. M.**

"Gastrointestinal Hemorrhage — Massive;
Discussion of Causes and Treatment"----------*Dr. James J. Gorman, El Paso*

**3:40 — 4:05 P. M.**

"Management of Congestive Heart Failure"----------*Dr. Ralph Homan, El Paso*

## SATURDAY, FEBRUARY 14

**9:00 — 9:25 A. M.**

"Early Recognition of Cerebral Palsy"----------*Dr. Basil K. Byrne, El Paso*

**9:25 — 9:50 A. M.**

"Treatment of Cardiac Arrhythmias"----------*Dr. Charles P. C. Logsdon, El Paso*

**9:50 — 10:15 A. M.**

"Management of Some Common Obstetrical Difficulties"----------*Dr. Gray E. Carpenter, El Paso*

**10:15 — 10:30 A. M.**

— INTERMISSION —

**10:30 — 11:15 A. M.**

"Care of Malignant Lesions of the Colon and Rectum"----------*Dr. Robert M. Moore, Galveston*

**11:15 A. M.**

Business meeting and election of officers

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# PROCTOLOGY 1952-1953 AWARD

The International Academy of Proctology takes pleasure in announcing its Annual Cash Prize and Certificate of Merit Award Contest for 1952-1953. The best unpublished contribution on Proctology or allied subjects will be awarded $100 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit.

This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contributions will be selected by a board of impartial judges, and all decisions are final.

The formal award of the First Prize, and a presentation of other Certificates, will be made at the Annual Convention Dinner Dance of the International Academy of Proctology in May of 1953.

The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, "The American Journal of Proctology and Gastroenterology."

All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of April, 1953. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Blvd., Flushing 55, New York.

# De Rebus Medicis Et Politicis

BY ROBERT B. HOMAN, JR., M. D., EL PASO, TEXAS
MEMBER OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

## ON VETERANS' CARE

In the January, 1952, issue of SOUTHWESTERN MEDICINE this column considered briefly the problem of Veteran's medical care. Attention was called to the fact that a Public Law, passed in 1924, was being used to allow the hospitalization of large numbers of non-service connected cases in Veteran's facilities. It was pointed out that there are now more than 20,000,000 veterans eligible for this "free" medical care and that the continuation of the present policy posed a serious threat to the civilian system of medical care. During the ensuing year there have been three separate investigations of the Veteran's Administration and its policies. Let us briefly take a look at some of the findings.

From the report of the A. M. A. Special Committee on Federal Medical Services, we find that the total number of Veteran's Administration beds has increased from 45,873 in 1936 to 119,736 in 1951; that the total number of admissions has increased from 130,455 in 1936 to 509,720 in 1951; that in 1951, 50.7 per cent of the tuberculous cases, 53.7 per cent of the psychotic cases, 72.4 per cent of other neurological cases, and 88.3 per cent of the general medical and surgical cases admitted were non-service connected; that this means that about two-thirds of the admissions were *not* service-connected! The average length of stay for general medical and surgical cases in 1950 was 30.8 days! In private general hospitals the figure is seven to 10 days — a figure which includes hospitalization of people of all ages and both sexes.

### EXPENDITURES GROW

A total of 21,258,217 days of hospitalization for non-service connected cases were provided in 1951. The total expenditures for V. A. medical services in the same year was $600,388,000. The V. A. and all students of this problem agree that this figure will grow larger as the veterans themselves grow older — as long as the present laws regarding non-service disabilities are on the statutes. The V. A. now operates 157 hospitals, 107 outpatient clinics, and 64 mental hygiene clinics. Plans have been made to add more hospital beds.

At a cost of $600,000 the management engineering firm of Booz, Allen & Hamilton has made a study and a report on the V. A. A number of its reorganizational suggestions have been accepted; others basically important have been rejected by the V. A. On the subject of non-service connected cases, this report calls on Congress to revise or clarify the laws on this vital subject. The management engineers state that they must assume that Congress must have intended that the V. A. render care to non-service connected cases because it (Congress) has authorized construction of more beds than are needed for service-connected cases. The report also states that 41,000 to 51,000 beds would be sufficient to care for future demands of service-connected cases. This is about one-third of the 131,000 beds the V. A. expects to have when its present building program is complete. The report states that it would take 25 per cent more beds than the latter figure to meet the requirements if non-service disabilities are to be included in the future. "Any one of the nation's anticipated total of approximately 22,000,000 veterans might, of course, become a candidate for hospital care in this final category."

### OCTOPUS

It is becoming more and more obvious to all people interested in this problem that the veteran's medical care program is becoming an octopus of far-reaching economic consequences. The private hospital system cannot compete with the Federal government in an economic race for trained personnel such as nurses and technicians. The private patient cannot afford the hospital charges which would be necessary to meet the inflationary wages offered by government facilities to this personnel. The continued growth of the system is being felt in hospitals throughout America. There must be a decision on this problem soon.

The A. M. A. House of Delegates at Denver in December, 1952, re-iterated its stand in opposition to hospitalization of non-service connected disabilities other than TB and

(Continued on Page 58)

# APHORISMS TRUTHS AND CONCEPTS CONCERNING THE GASTRO- INTESTINAL TRACT

By Andrew M. Babey, M. D., Las Cruces, New Mexico

(1)

"Gastric retention alone is not evidence of organic obstruction, for retention can occur with lack of peristalsis due to worry, headache, emotion, etc."—E. EMERY, *M. Clin. North America,* 19: 1519, March 1936.

(2)

"Buccal pigment does not by itself prove that Addison's disease is present, for precisely similar pigmentation in the mouth is observed in some cases of pernicious anemia, of phthisis without suprarenal disease, and of malignant disease, whilst negro blood in the ancestry often causes buccal pigmentation in perfectly healthy persons." — H. FRENCH, *Differential Diagnosis,* Wm. Wood & Co., N. Y., 1936, p. 635.

(3)

"Skillful neglect does not succeed with ulcerative colitis." — BURRILL CROHN, *Am. J. Digest, Dis. & Nutrition,* 2: 343, 1935

(4)

"Among the many sources of such mistakes by which the physicians may be misled and induced to conclude that the liver is the seat of disease when in fact it is not, feculent accumulations in the colon are perhaps the most frequent." — RICHARD BRIGHT, *Clin. Memoirs on Abdominal Tumors,* The New Sydenham Soc. London, 1861, p. 242.

(5)

"Never decide against obstruction as the result of the first enema; give a second two hours later, and if necessary, a third."—W. OGILVIE, *Brit. M J.,* 1: 2, 1937.

(6)

"In all the conditions involving impairment of the liver, the administration of glucose is of great value."—J. BOLLMAN, *S. Clinics N. America,* 5: 871, June 1925.

(7)

"Enlarged spleen may be the only evidence of cirrhosis of the liver."—S. J. GEE, *Med. Lectures & Clinical Aphorisms,* Oxford Med. Publications, London, 1908, p. 273.

(8)

"A jaundiced skin may never wholly recover its natural color in chronic cases, even when the cause of the jaundice is removed."—S. J. GEE, *loc. cit.*

(9)

"There are only three things that give a nodular liver: syphilis, cancer and cirrhosis. In syphilis we do not ordinarily get nodules; we get masses as big as a fist. In cirrhosis the nodules are so small we cannot feel them. Cancer is the only disease with nodules of the size that we can feel." — RICHARD CABOT, *New England J. Med.,* 205: 203, 1931.

(10)

"Anybody with any considerable jaundice has albumin in the urine."—RICHARD CABOT, *loc. cit.,* p. 203.

(11)

"About 1/3 of cirrhosis cases have a small liver, about 1/3 a normal liver, and 1/3 a big liver."—RICHARD CABOT, *loc. cit.,* p. 204.

(12)

"The intestine is like the kidney in that a long standing disease may show clinical symptoms only now and then, presenting itself suddenly under the guise of an acute disease. They remain diseased through long symptomless periods." — RICHARD CABOT (Source uncertain).

(13)

"We often see gas in the small intestine in bedridden or sick patients." — AUBREY HAMPTON, *New England J. Med.,* 205: 727, 1931.

(14)

"We think that if the diaphragm moves there is no pus immediately below it, between the diaphragm and the liver." — GEORGE HOLMES, *New England, J. Med.,* 205: 729, 1931.

(15)

"Fever is a constant accompaniment of cirrhosis and should be expected with it

rather than not expected with it."—CHESTER JONES, *New England J. Med.*, 205: 968, 1931.

(16)

"The fact that the barium enema was negative does not necessarily rule out a lesion in the colon. A negative barium enema means a normal colon in about 70% of the cases."—GEORGE HOLMES, *New England J. Med.*, 202: 183, 1930.

(17)

"Barium by mouth in an obstructing lesion of the large bowel is an extremely dangerous procedure." — L. MCKITTRICK, *New England J. Med.*, 202: 494, 1930.

(18)

"One should never be influenced against the diagnosis of malignant disease of the colon solely on the basis of negative X-ray findings."—L. MCKITTRICK, *loc. cit.*, p. 495.

(19)

"Proctoscopy properly done and interpreted is of much more value in malignancy of the lower bowel than X-ray." — L. MCKITTRICK, *loc. cit.*, p. 495.

(20)

"A negative barium enema does not rule out neoplasm of the rectum or of the sigmoid, for X-rays of this region are notoriously untrustworthy." — C. SHEDDEN, *New England J. Med.*, 202: 1017, 1930.

(21)

"Many people with jaundice have diarrhea."—RICHARD CABOT, *New England J. Med.*, 202: 1261, 1930.

(22)

"I am very skeptical of any report of black stools not seen by a doctor or nurse. People's reports of the color of stools are notoriously inexact."—RICHARD CABOT, *New England J. Med.*, 199: 287, 1928.

(23)

"One set of gastro-intestinal X-rays is never to be relied upon implicitly as regards disease either in the stomach or in the intestinal tract." — ED. YOUNG, JR., *New England J. M.*, 199: 383, 1928.

(24)

"... the only sure method of distinguishing between idiopathic ulcerative colitis and chronic dysentery was the isolation of dysentery bacilli, preferably from material obtained by gently curetting the diseased bowel during sigmoidoscopy."—HAMILTON FAIRLEY *Proc. Roy. Soc. Med.*, 26: 1062, 1932-33.

(25)

"To cause sugar to appear in the urine in acute pancreatitis there must be an almost complete destruction of the pancreas, and if that occurs death usually takes place within a few hours." — DANIEL F. JONES, *New England J. Med.*, 199: 538, 1928.

(26)

"The duodenal bulb is apt to be deformed in gall bladder disease and may be misleading."—GEORGE HOLMES, *New England J. Med.*, 198: 867, 1928.

(27)

"You perceive, therefore, that in jaundice everything denoting an unusual state of the nervous system, whether it be too much sleep or too little, demands your attention." — ROBERT GRAVES, *A System of Clin. Med.*, Barrington & Haswell, Phil., 1848, (3rd. Amer. Ed.), p. 384.

(28)

"When a patient under treatment for gastric ulcer becomes irritable, refuses food and complains of headache, alkalosis and not boredom is the probable cause." — H. FRENCH, *Differential Diagnosis*, Wm. Wood & Co., N. Y., 1936, p. 186.

(29)

"Any child with severe acidosis or in diabetic coma frequently has abdominal pain." — RICHARD CABOT, *New England J. Med.*, 195: 1120, 1926.

(30)

"In children, massive tumours of the abdomen are not uncommon and, as a rule, are either sarcomata of the kidney or of the retroperitoneal glands. The kidney tumours are the more frequent. Both develop painlessly." — W. OSLER, *Lectures on the Diagnosis of Abdominal Tumours*, D. Appleton & Co., N. Y., 1899, p. 161.

(31)

"When a stool is clay colored the conclusion that bile is absent is not warranted without a chemical test for bile. The color of the stool in chronic pancreatitis may vary from a grey to a glistening white, or when the fat is in crystalline form it may resemble aluminum paint."—VIRGIL SIMPSON, Diseases of Pancreas, *Kentucky M. J.*, 32: 108, 1934.

(To Be Continued)

# ARTHRODESIS OF THE HIP JOINT*

By W. Compere Basom, M. D., M. S. Or., F. I. C. S., El Paso, Texas

Most patients have a distinct aversion and horror at the mention of the loss of joint function. This is particularly true with the major joints of the body and it is one of the major fears, for instance, when a joint operation is necessary. Nearly all patients who need a torn meniscus removed fear that removal of the joint fluid will leave a so-called dry joint or removal of the meniscus is a bad thing. The same attitutde applies in the hip because all patients are afraid of getting a stiff joint.

However, in the case of a working man who must be on his feet for long periods at a time and also one who must be able to do heavy hard lifting and the like, a stiff hip joint without pain is much better than a movable joint with pain.

**FIGURE I.**

*Reveals x-ray with two tibial bone grafts in place running into the arthrodesed hip joint. The joint is solidly arthrodesed and the evidence of old cavity was due to a gunshot wound. This of course, had been carefully cleaned out and all infection eliminated long before the arthrodesis was ever done. This patient had an excellent painless hip region following the conclusion of this procedure.*

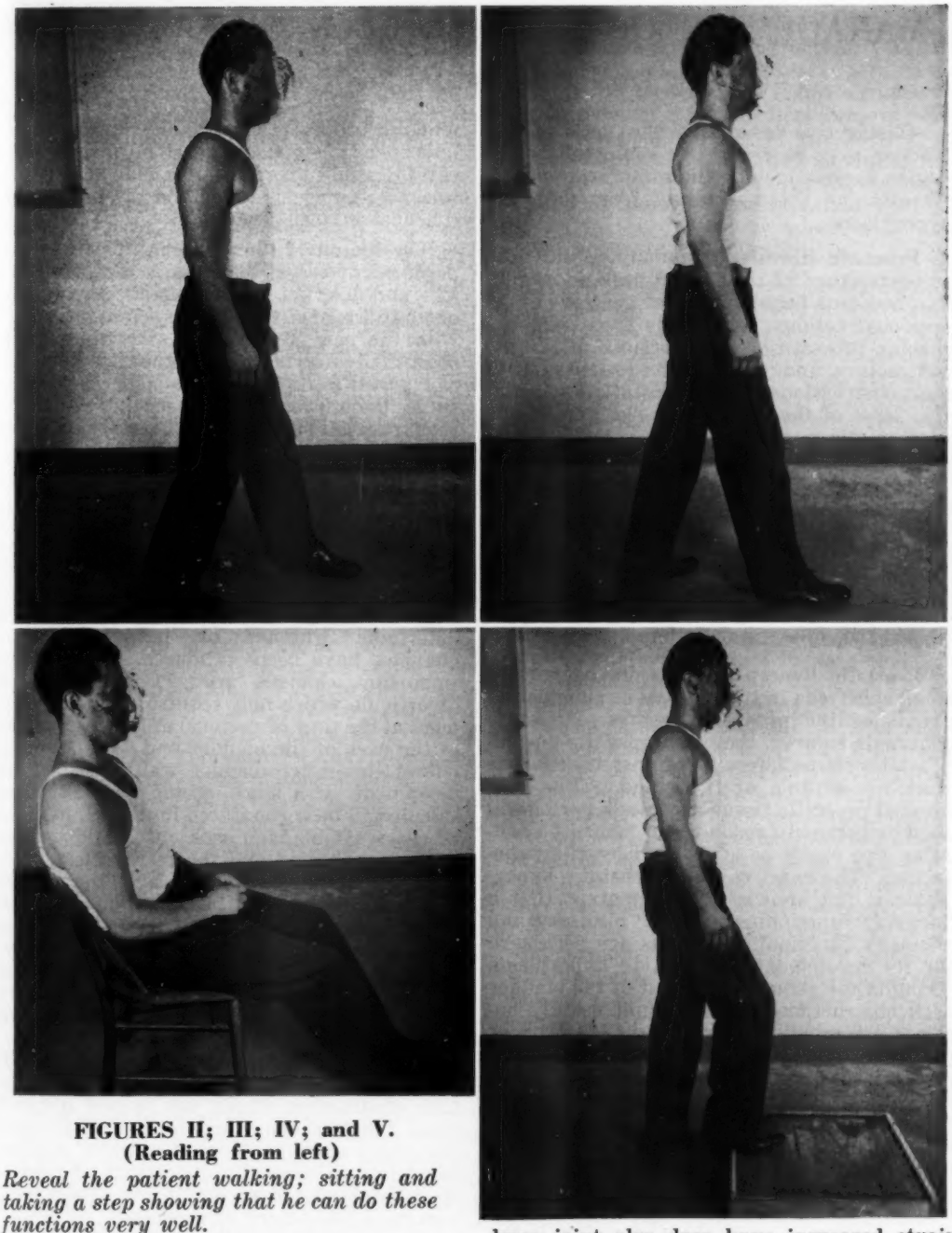
A joint which is hopelessly damaged either mechanically or due to one of the various infections will give a considerable amount of pain and disability to the owner. Of course, at this time the popularity of the various prosthesis for restoring a hip joint and the various head substitution apparatuses are very popular. It is amazing how many modifications there have been on the original Judet femoral head substitution. The procedure is not very many years old and the patients have not had time to try these things out for a long time to see if they stand up with time. It is my opinion that any foreign material which is attached to the bone will eventually become loose if there is a strain through it particularly one of weight-bearing. Therefore, I do not feel that the plastic substitutions or even the arthroplasties are the answer to a fairly young individual's problem who has a painful particularly weight-bearing joint such as the hip joint.

The operative procedure is fairly extensive and the Smith-Petersen approach exposing the hip joint is an excellent one. In this procedure the incision curves over the iliac crest and distally somewhat from the anterior superior spine of the ilium. Muscles are detached from this area on the lateral side down far enough to expose the hip joint. The joint itself is carefully denuded of cartilage and then grafts either iliac or tibial grafts or bone bank grafts are used to bridge from the femur into the acetabulum. This gives one of the surest methods of arthrodesis. There are various methods of internal metal fixation, however, the average hip arthrodesis patient is usually young enough to withstand a spica cast and prolonged immobilization and as yet I have not adopted the extensive internal fixation apparatus. There is an excellent apparatus which bolts on to the ilium and fits into the femur with an intramedullary rod. This apparatus will markedly shorten the patient's hospitalization period. However, by the use a single hip spica cast in a strong individual, the patient may be ambulatory in a month or six weeks.

The cast immobilization should continue until the monthly x-ray check-up reveals firm union with good bony trabeculations running across the hip joint itself.

At the end of that time the patient can start on a period of gradual mobilization and then eventually can return to work.

* From the medical program Big Bend Counties Medical Society given at Fort Stockton at the Memorial Hospital, February 4, 1952.



**FIGURES II; III; IV; and V.**
**(Reading from left)**
*Reveal the patient walking; sitting and taking a step showing that he can do these functions very well.*

The optimum hip joint position is one of slight flexion; very slight adducation and this loss of joint movement is not a bad or serious hindrance. It does throw more strain on the lower back, lumbo-sacral spine and, therefore, the patient should have a good back if this is to function well. The patient's knee joint also does have increased strain but this is usually not of great importance.

The patient usually can sit, stand and walk very well and I personally feel that a good hip arthrodesis is a good permanent method for use to relieve pain for many years to come in a carefully and well selected individual case.

# MANAGEMENT OF BLADDER NECK OBSTRUCTION*

By Edgar Burns, M. D., New Orleans

Obstructive lesions at the neck of the bladder may be benign or malignant. The *benign lesions* include those due to prostatic fibrosis and those resulting from prostatic hyperplasia.

**Prostatic fibrosis,** commonly referred to as contracture of the vesical neck or median bar, accounts for about 10 per cent of vesical neck obstructions. It probably always follows chronic prostatitis, which results in fibrous contracture, and is encountered earlier in life than obstructions due to prostatic hyperplasia. Most of the glandular structures of the prostate lie posterior to the vesical outlet; and fibrosis in this area produces shortening of the prostatic urethra and elevation of the posterior lip, which constitutes a dam at the internal vesical orifice, more commonly referred to as median bar. In this type of obstruction the prostate is not enlarged and there is no line of demarcation between the obstructing tissue and the remaining portions of the prostate.

**Prostatic hyperplasia** has its origin as small spheroids in the mucosal or submucosal glands of the prostatic urethra. As these spheroids enlarge, they compress the normal prostatic tissue laterally against the fibrous anatomic capsule of the gland. This compressed prostatic tissue becomes a peripheral shell or surgical capsule from which the adenoma can easily be enucleated by blunt dissection. The exact cause of prostatic hyperplasia is not known. It is apparent that a normally functioning anterior pituitary and normally functioning testicles are necessary for its devolpment. Prostatic hyperplasia accounts for about 80 per cent of the bladder neck obstructions in adults and usually becomes symptomatic in men past 50 years of age. The parts of the prostate involved in prostatic hyperplasia are those immediately in contact with the prostatic urethra that is, the median and two lateral lobes. The size to which the gland may grow varies in each individual. Although the gland may be only slightly enlarged, the hypertrophied tissue may project into the urethra in such a manner as to cause considerable obstruction to the vesical outlet. On the other hand, the hyperplasia may develop to such an extent that the gland weighs 200 to 300 Gm. Because of this wide variation in size produced by prostatic hyperplasia, emphasis must be placed upon careful study of each individual in order to select an appropriate method for removal of the obstructing tissue.

**Carcinoma of the prostate,** in perhaps 90 per cent of cases, develops in the posterior lobe and does not produce urinary symptoms until it invades the urethra and interferes with the passage of urine. By this time it has usually broken through the capsule posteriorly and is no longer amenable to radical surgical removal. Bladder neck obstruction from prostatic carcinoma ,therefore, is a late manifestation of the disease.

## PREOPERATIVE MANAGEMENT

In the management of bladder neck obstruction it is important not only to evaluate the character of the obstructing lesion but also to study the urinary tract above the point of obstruction in order to determine whether or not irreversible changes have been produced. Among the important changes are: 1) formation of diverticula which may require surgical treatment at the time of removal of the obstruction at the neck of the bladder and 2) a thinning out of the entire bladder wall with the development of a hugh atonic sac. Bladder calculi will be encountered in a small number of cases. If bladder neck obstruction exists for a long period and the intravesical pressure is maintained at a high level, the ureters and renal pelves may become dilated and in some cases thinning out of the renal cortex may occur with irreversible renal damage. Urinary infection is usually present in these cases and the changes in the renal cortex produced by infection add to the damage that occurs as a result of back pressure.

In the management of bladder neck obstruction blood studies are important. Prostatic obstruction which has caused reduced renal function is commonly associated with secondary anemia. Moreover, there is some blood loss in prostatic operations and postoperative hemorrhage may occur. Therefore, a normal hematocrit is essential.

Since prostatic obstruction occurs in the age group which has been subjected to the stresses and strains of life, some degree of cardiovascular damage is present in a considerable number of cases. For this reason, the cardiovascular system should be evaluated preoperatively by a competent internist.

* Read before the meeting of the Southwestern Medical Association, Oct. 18-20, 1951, in El Paso.

* From the Departments of Urology, Ochsner Clinic and Tulane University, New Orleans.

Preoperative preparation of patients for removal of bladder neck obstructions thus includes: 1) evaluation of renal function (if results of renal function tests are below normal levels, drainage should be instituted until maximum improvement takes place); 2) elimination of clinical evidence of infection in the urinary tract; 3) restoration of hematocrit level to normal; and 4) careful evaluation of the cardiovascular system with treatment in indicated cases, chiefly myocardial weakness and coronary disease.

## OPERATIVE PROCEDURES

There are at present four methods by which obstructions at the bladder neck may be removed: 1) transurethral resection, 2) suprapubic transvesical prosatectomy, 3) retropubic prostatectomy and 4) perineal prosatectomy. No one of these can be employed for all types of obstruction and any attempt to apply a single method to all types will be followed by unnecessary complications and poor end results.

Transurethral resection gained wide popularity about twenty years ago. Many urologists acquired the ability to remove large amounts of tissue in one stage. Consequently, there was a rather widespread attempt to apply this technic to all types of obstructive lesions and there are still some urologists who rarely resort to any other method. This approach is especially adaptable to prostatic obstructions due to fibrosis. The amount of obstructing tissue is small and can easily be removed in a short time. Bleeding can be adequately controlled and there should be few operative or postoperative complications of importance. Prostatic carcinoma producing bladder neck obstruction should probably not be removed by any other method. The architecture of the prostatic urethra is distorted in this stage of the disease but under adequate vision the prostatic urethra can be reconverted into a normal looking and normally functioning canal. The smaller obstructions produced by prostatic hyperplasia are equally adaptable to removal by transurethral resection. I am quite convinced, however, that better results will be obtained if the larger obstructions are removed by some type of open approach and I believe that this is gradually becoming the consensus of urologic surgeons. If all obstructing tissue is not removed, the results are unsatisfactory even though the patient may be able to urinate and completely empty the bladder. Residual masses of prostatic tissue predispose to postoperative hemorrhage, may become infected and cause frequency, burning, urgency and tenesmus, are usually associated with persistent urinary infection and in many cases develop to the point of recurrent obstruction. We have had this experience in patients operated upon on our own service and it has also been the experience in other medical centers. Since the future well being of the patient with prostatic obstruction depends largely upon the completeness with which the obstructing tissue is removed, consideration should be given to the method by which this can be most adequately accomplished.

**Suprapubic transvesical prostatectomy** is an approach that has been in wide use for many years. Less urologic surgical training is required for removal of a prostate by this method than by some of the other approaches. It carries, however, a slightly higher mortality rate, even in the hands of accomplished urologic surgeons. It may be indicated in some patients who have an associated lesion in the bladder and particularly in those who have had a previous suprapubic cystostomy for the purpose of drainage and still have the suprapubic tube in place.

**Perineal prostatectomy,** like the suprapubic approach, has been widely used for many years and in some medical centers it is still the method of choice for large adenomas that should be removed by some kind of open procedure. A specialized type of training is required in order to obtain satisfactory results by this approach. It has been recommended for the subtotal removal of a prostate containing calculi. However, rarely have I encountered this type of prostate which could not be adequately treated by transurethral resection with less chance of unpleasant complications. The possible complications following perineal prostatectomy are urinary incontinence, which in some cases may be total and permanent, rectal or urinary fistulas and usually loss of the ability to have an erection. Sexual function in many cases in this age group is not important but in an individual who has retained his sexual vigor, loss of this function following an operative procedure becomes an objectionable feature.

The third and newest open approach to the prostate is the *infravesical retropubic route.* This technic was devised by Millin of England who first performed the operation in August 1945. Since then it has become popular with urologic surgeons throughout the world for removal of the larger bladder neck obstructions. I have found a modification of it highly satisfactory for removal of bladder neck obstructions in children. The retropubic approach is especially applicable to large, benign prostatic hyperplasia and the larger the prostate, the easier it is to

remove by this route. Associated lesions of the bladder are not contraindications to this approach.

This approach appears to have several distinct advantages over the other open methods. It is direct, usually through a transverse incision just above the pubis, which provides sufficient exposure of the retropubic space and allows for adequate disposal of the large veins usually found in the preprostatic area. A transverse incision is made in the prostatic capsule just below the internal vesical orifice through which the adenoma can be easily removed. A particular advantage that this approach offers is the ease with which hemorrhage can be adequately controlled. After the prostate has been enucleated, the prostatic vessels can be easily visualized and bleeding stopped, preferably by transfixion sutures. The incision in the prostatic capsule is closed by one continuous chromic catgut suture, which is both hemostatic and water tight. This eliminates postoperative drainage of urine through the incision in the majority of cases. Drainage is accomplished by means of a transurethral catheter, which is usually removed on the fourth or fifth day after which normal urinary function is restored. We have been impressed by the lack of operative shock in the majority of cases. There is less postoperative discomfort than following any other prostatic operation with the exception of transurethral resection of small glands. Moreover, there is a remarkable absence of frequency and burning after the catheter has been removed. Patients often do not get up more than two or three times at night during the early postoperative period and the urine is usually free of pus and organisms by the end of the fourth to sixth postoperative week.

## COMPLICATIONS

**Osteitis pubis** is an infrequent but important complication that may follow retropubic prostatectomy. We have encountered it six times in approximately 200 retropubic prostatectomies. Although many reasons for its occurrence have been suggested, none have been satisfactorily proved. We are convinced that it is not due to infection, since these patients do not have fever and they all recover without suppuration. Because of the character of the pain, the decalcification of bone, the duration of the disability, and the eventual complete recovery, we have thought for some time that it is most likely due to a circulatory disturbance. It is well known that aberrant arteries are encountered in the retropubic space, branches going to the pubis, and it seems entirely possible that interruption of this blood supply may account for the disability until the circulation is reestablished. On this basis the last two patients that we have encountered in whom osteitis pubis developed have been treated by repeated sympathetic blocks. Both completely recovered and were able to go home at the end of ten days. Osteitis pubis may also follow other operations upon the prostate. We have encountered it following perineal prostatectomy and transurethral resection. It has also been reported in patients who have not been operated upon.

**Thrombophlebitis** may develop after any operation upon the prostate and may be an extremely serious complication. The patient should be carefully observed postoperatively in order to detect thrombophlebitis before a fatal embolus has a chance to occur. The characteristic leg signs with a pulse rate out of proportion to the height of the temperature are usually sufficient to justify the diagnosis. Treatment should be promptly instituted and I am convinced that venous ligation is safer than treatment with various anticoagulants. The involved veins should be ligated at whatever level necessary to get above the area of thrombosis, even to the extent of ligating the vena cava. We have been impressed with the ease with which the vena cava could be ligated, the rapid recovery and the remarkably slight disability that has resulted from it.

**Urinary infection** follows all operations upon the prostate. In the majority of cases it is secondary to the healing process in the prostatic urethra and does not extend above the bladder. It is not of any clinical importance and if all the obstructing tissue has been removed the urine usually becomes sterile by the end of the second or third postoperative month ,even without the administration of urinary antiseptics.

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## De Rebus Medicis Et Politicis

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N. P. cases. It instructed the Board of Trustees to ask representatives of the A. M .A., American Dental Society, American Hospital Association, the Veteran's Administration and the various other Veteran's organizations to sit down together and work out a solution to this problem. This group should be able to make recommendations to Congress with justice to the tax-payer, the private system of medicine, and the veterans. Meantime, it would do no harm to let your congressmen and senators know what you think about the situation.

# PLACENTA ACCRETA — A CASE REPORT

By J. J. Johnson Jr., M. D., Las Vegas, New Mexico

Placenta accreta is an unusual complication of pregnancy. Only 118 authentic cases having been reported, according to Meyer and Ashworth[1] in 1940. This complication of pregnancy is usually regarded as one that is accompanied immediately by profuse hemorrhage and shock, and followed by sepsis.[2] Treatment has varied from immediate hysterectomy[1&5] to watchful waiting.[3] In recent years there has been a trend to conservative treatment.[3&4] This case is presented because of an extended period of conservative treatment under exceptional circumstances.

Mrs. N. S. a 40 year old white female, was admitted to the hospital January 6, 1952, because of uterine cramps and bloody show. She was five months pregnant and had had two previous admissions to the hospital during this pregnancy, both for cramps and bleeding. The patient had had three miscarriages with no live births and had had no other serious illness. The uterus was the size of a six months pregnancy with a tender mass in the right lower segment of the uterus. Wassermann negative; Rh factor positive; RBC 3,850,000; WBC 15,600; Urine negative. The physical examination was otherwise not remarkable. The patient miscarried spontaneously January 12, 1952. The fetus was macerated and the cord was torn from the placenta. There was very little bleeding at the time of the miscarriage and no increase followed the expulsion of the fetus. The placenta was not expressed by firm pressure on the fundus of the uterus and no further attempt was made to dislodge the placenta from the uterus after examination disclosed that the placenta was not lying free in the vagina, or incarcerated in the cervix. She was given 300,000 units of duracillin daily and .0002 Ergotrate tid. The temperature remained normal and the patient was allowed up in her room on the third day after vaginal bleeding had stopped.

## DIAGNOSIS GIVEN

The patient was given the diagnosis of uterin fibroids with degeneration and retained placenta and hysterectomy recommended. She asked for a trial of conservative therapy and because of her extreme desire to preserve her uterus she was allowed home on the seventh day, without medication, in good condition, and without vaginal bleeding. She was advised to report at once if bleeding occurred. She was examined at monthly intervals and at each examination the uterus was found to be 3-4x normal size with subserous fibroid tumors, and a patulous cervix with a firm fixed mass at the internal os. The patient felt well during the entire period and was allowed reasonable activity complaining only of profuse vaginal discharge. She agreed to hysterectomy after the second month and was re-admitted to the hospital March 19, 1952. RBC 4,880,000; WBC 12,000; HBG 15.0G. An attempt to remove the placenta from the uterus through the cervix resulted in immediate profuse hemorrhage. A line of clevage could not be established and the uterus was packed and 500cc of blood given. The following morning the RBC was 3,500,000; HBG 11G. 1000cc whole blood was started and supra vaginal hysterectomy was done. She had an uneventful postoperative course. The temperature rose to 100°F the second postoperative day and returned to normal the same day. RBC on that day was 4,930,000; HBG 12.8. She was dismissed from the hospital on the 8th postoperative day with the wound healed and without complaint.

The pathological studies were done by Aaron E. Margulis, M. D., Santa Fe, New Mexico, his diagnosis:

1. Leiomyomata of uterus showing red degeneration.
2. Hemorrhagic necrosis of retained placenta accreta.
3. Chronic myometritis.

## DISCUSSION

Bleeding associated with placenta accreta does not ordinarily originate spontaneously at the site of a placenta.[3] In complete placenta accreta there is ordinarily no excessive bleeding unless repeated Crede maneuvers or manual extraction has been employed.[3] These observations and the fact that complete placenta accreta is intimately adherent to the uterine wall and difficult if not impossible to dislodge, led the author to further liberalize the conservative treatment in this case. Having assumed that ordinary and reasonable activity of a patient will not dislodge a placenta that is difficult to dislodge manually and deliberately, the patient was allowed home to resume ordinary household activity. It was not felt that undue risk was being taken as the patient was within min-

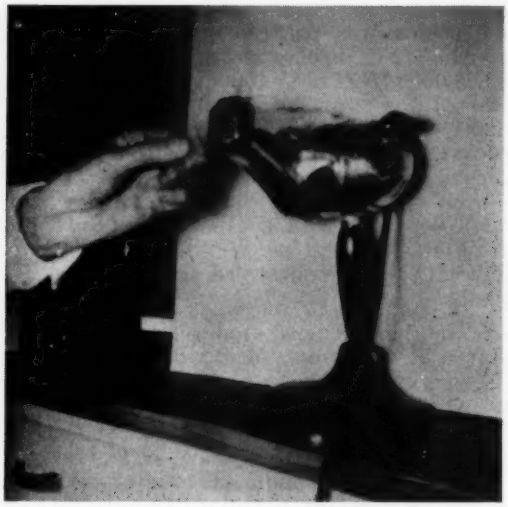
(Continued bottom Page 60)

# RAPID METHOD OF DRYING SLIDES AND USE OF VIBRATOR IN APPLICATION OF ELECTRODES

By R. D. Haire, Jr., M. D., Roswell, N. M.

A few minutes saved each will add up to many days at the end of a year. Since the numerous new drugs will require more laboratory tests and especially blood counts; and since the average doctor will do many more of the simpler tests the inclosed illustration shows use of a cheap hair dryer. It will cost about $5 and speed up the work of your office nurse or technician.

The illustration is self-explanatory.



Much of the work of electrocardiographs is in getting a good contact for your jelly and the electrodes. This can be facilitated by using a cheap vibrator and will insure you good standardization, as well as cutting in half the time required to make same. The patient's time is valuable also. It may surprise you how your technician will welcome this little suggestion. Cost of cheap vibrator is between $5 and $10.

The illustration is self-explanatory.

(Continued from Page 59)

utes of the hospital, alert, and fully informed of the possible dangers involved.

## CONCLUSIONS

1. Complete placenta accreta may be conservatively managed safely over an extended period of time.
2. Vigorous attempts to remove placenta accreta manually should be attempted only after preparations for laparotomy and blood transfusions have been completed.
3. Attempts to remove placenta accreta manually should not be undertaken until all thought of conservative treatment has been abandoned.
4. Reasonable efforts should be made to preserve the uterus for future pregnancies by conservative treatment of placenta accreta.
5. Although conservative treatment resulted in failure to preserve the uterus in this instance, the postulation that conservative treatment of this disease can be done safely has been enhanced.
6. Elective hysterectomy is not precluded nor the morbidity of the operation increased by conservative treatment.
7. Vigorous aggressive treatment of a retained placenta may convert a benign situation into a grave obstetrical emergency in a case of undiagnosed placenta accreta.

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